



9/12/2008

Indiana Access To Recovery (ATR) – Client Choice Form

INATR - 001

I _____, IDOC# _____ understand that the Indiana Access
(Enter Client's Name) (If applicable)
to Recovery is a voluntary program and that my participation in the program is because I want to recover from my addictions.

I understand that there are a number of providers qualified to provide any service that I may require during my participation in the ATR program.

I also understand that I may choose the providers that provide services to me while I participate in the program.

I understand that the following providers are ready to provide Indiana ATR clients with recovery consultation.

Agency	Phone	Fax
Amethyst House	812-401-3415	812-401-3413
Churches Embracing Offenders	812-422-2226	Call before faxing
Counseling for Change	812-491-2615	812-422-1299
Evansville Goodwill Industries	812-474-2222	812-962-1266

From the above list I have selected _____ to provide this service.
(Enter Name of Care Coordination Agency)

No one has exerted pressure on me to select this particular provider and I am confident that this provider is best suited to meet my needs for recovery consultation.

I understand that if I find that this provider does not meet my needs, I may select another provider to replace this provider at any time.

I understand that _____ may not be willing or have the ability to
(Enter Name of Care Coordination Agency)
provide recovery consultation to me, in which case I will need to select a different provider.

I understand that the Recovery Consultant will need to contact me. I authorize my chosen Recovery Consultant to contact me by contacting me at the following:

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

I authorize the referral agency to release my information to help the Recovery Consultant contact me:

Referral Agent: _____ Phone _____

Referral Agency: _____

_____/_____/_____
Signature Date